Eastside Marriage and Family Therapy,LLC

CREDIT CARD AUTHORIZATION FORM

It is your consent to make payment for services rendered. This form will be securely stored in the clinical file and may be updated upon request at any time. Services being paid by anyone other than the client DOES NOT give them access to any of the client's confidential information.

In the case of a missed appointment, failing to cancel an appointment within 24 business hours of the scheduled time, or if a check is returned unpaid, you will be charged the full session fee. An additional $35 fee will be assessed for returned checks and inaccurately disputed charge-backs.

I, _____, hereby authorize Kristine Natterstad, MMFT, LMFT/S Eastside Marriage & Family Therapy, LLC to bill my credit card at the usual fee for professional services including all of the following:

- Appointments that I elect to pay for by credit card
- Missed appointments / No Shows
- Telephone and email consultations
- Appointments that I have canceled with less than 24 business hours notice
- Returned checks / Inaccurately disputed charge-backs
- There is a $5 service charge added to the usual fee for every credit card transaction.
- For (client's name): _____

For New Clients scheduling the first appointment, this form must be returned to Kristine Natterstad, MMFT, LMFT/S Eastside Marriage & Family Therapy, LLC (by email, fax or in person) one week prior to the first scheduled appointment in order for that time to be reserved. If the first appointment is scheduled less than one week out, this form is due the same day that the client calls/emails to make their first appointment.

Credit Card / Debit Card Type (check one):

• Visa • MasterCard • Discover • American Express Card #: _____ Expiration Date: _____ Verification/Security Code (3-digit code on back of card): _____

Name as Printed on Card: _____

Billing Address: _____

City: _____ State: _____ Zip: _____

By signing below I am authorizing Kristine Natterstad, LMFT/S, Eastside Marriage & Family Therapy, LLC to bill my credit card at the usual fee (plus $2 credit card transaction fee) for professional services as described above.

Signature: _____ Date: _____

Printed Name: _____